211 CMR 38.00: COORDINATION OF BENEFITS (COB)

Section

38.01: Authority

211 CMR 38.00 is promulgated in accordance with the authority granted to the Commissioner of Insurance by M.G.L. Chs. 175, 176A, 176B, 176C, 176D, 176E, 176F, 176G and 176I.

38.02: Purpose and Applicability

The purpose of 211 CMR 38.00 is to establish an order in which plans pay their claims when a person is covered by more than one plan. Any plan which contains a Coordination of Benefits provision must comply with 211 CMR 38.00. A plan that does not contain such a provision may not take the benefits of another plan into account when determining its benefits.

38.03: Definitions

As used in 211 CMR 38.00, the following words shall mean:

Allowable Expense: the necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition. However, items of expense under coverages such as dental care, vision care, prescription drug or hearing aid programs may be excluded from the definition of allowable expense. A plan which provides benefits only for any such items of expense may limit its definition of allowable expense to like items of expense.

When a plan provides benefits in the form of services, the reasonable value of each service will be considered as both an allowable expense and a benefit paid.

When a plan uses capitation as the method of paying its providers of services, the reasonable value of such services shall be utilized as the basis of determining payment.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under the above definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

When COB is restricted in its use to a specific coverage in a contract (for example, major medical or dental), the definition of allowable expense shall clearly identify the corresponding expenses or services to which COB applies.

Claim: a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

(a) services (including supplies);
(b) payment for all or a portion of the expenses incurred;
(c) a combination of 211 CMR 38.03: Claim(a) and (b); or
(d) an indemnification.

38.03: continued

Claim Determination Period: the period of time, which must not be less than 12 consecutive months, over which allowable expenses are compared with total benefits payable in the absence of COB, to determine whether over-insurance exists and how much each plan will pay or provide. The claim determination period is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person may be covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period.

As each claim is submitted, each plan is to determine its liability and pay or provide benefits based upon allowable expenses incurred to that point in the claim determination period. That determination is subject to adjustment as later allowable expenses are incurred in the same claim determination period.

Coordination of Benefits ("COB"): a provision establishing an order in which plans pay their claims.

Group-type Contract: a contract for coverage which is not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group.

Hospital Indemnity Benefits: benefits provided during hospital confinement on other than an expense incurred basis.

Plan: a form of coverage with which coordination is allowed. The definition of plan in the group contract must state the types of coverage which will be considered in applying the COB provision of that contract. Plan shall include:

(a) group insurance and group subscriber contracts;
(b) uninsured arrangements of group coverage;
(c) group coverage through HMOs and other prepayment, group practice and individual practice plans;
(d) group-type contracts may be included in the definition of plan at the option of the insurer or the service provider and the contract client, whether or not uninsured arrangements or individual contract forms are used and regardless of how the coverage is designated;
(e) the amount by which hospital indemnity benefits exceed $100 per day; and
(f) the medical benefits coverage in automobile policies to the extent permitted by law.

Plan shall not include:

(a) nongroup coverage except for coverage described in 211 CMR 38.03: Plan(d) through (f) above, or when a nongroup plan chooses to coordinate with other nongroup plans;
(b) Medicare or other governmental benefits except to the extent permitted by law;
(c) student accident coverages, Qualifying Student Health Insurance Programs ("QSHIPs") or other student health plans when designated as "excess only" or "always secondary plan"; and
(d) a plan under Medicaid, or any other plan when, by law, its benefits are secondary to or in excess of those of any private insurance plan or other nongovernmental plan.

Primary Plan: a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if either:

(a) the plan either has no order of benefit determination rules, or it has rules which differ from those permitted by 211 CMR 38.00 (There may be more than one primary plan.) or
(b) all plans which cover the person use the order of benefit determination rules required by 211 CMR 38.00, and under those rules the plan determines its benefits first.

38.03: continued

Secondary Plan: a plan which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules of 211 CMR 38.00 decide the order in which their benefits are determined in relation to each other. The benefits of each secondary plan may take into consideration the benefits of the primary plan or plans and the benefits of any other plan which, under the rules of 211 CMR 38.00, has its benefits determined before those of that secondary plan.

Qualifying Student Health Insurance Programs ("QSHIPs"): student health programs established pursuant to St. 1988, c. 23, § 22 and complying with guidelines or regulations issued by the Department of Medical Security.

38.04: COB Contract Provision

Any plan which contains a Coordination of Benefits provision must provide information to persons covered under the plan about its COB provision and the rules used to determine primary and secondary coverage and to determine and calculate allowable expense.

38.05: Rules for Coordination of Benefits

(1) The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist. A plan that does not include a coordination of benefits provision may not take the benefits of another plan into account when it determines its benefits. There is one exception: a contract holder's coverage that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder.

(2) A plan may take the benefits of another plan into account only when, under these rules, it is secondary to that other plan.

(3) The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.

(4) If two or more plans cover a dependent child whose parents are not separated or divorced, the order of payment is:

(a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year.

(b) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the parent for a shorter period of time.

(c) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born.

(d) If the other plan does not have the rule described above, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the birthday rule will determine the order of benefits.

(5) (a) If two or more plans cover a dependent child whose parents are divorced or separated, the order of payment is:

1. the plan of the parent with custody of the child;
2. the plan of the spouse of the parent with the custody of the child; and
3. the plan of the parent not having custody of the child.

(b) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. 211 CMR 38.05(5)(b) does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has the actual knowledge.

38.05: continued

(c) If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in 211 CMR 38.05(4).

(6) The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(7) If none of the above rules determines the order of benefits, the benefits of the plan which covered a person longer are determined before those of the plan which covered a person for the shorter term.

(a) To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.

(b) The start of a new plan does not include:

1. a change in the amount or scope of a plan's benefits;
2. a change in the entity which pays, provides or administers the plan's benefits;
3. a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

(c) The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force.

38.06: Prohibited Coordination and Benefit Design

(1) A group contract may not reduce benefits on the basis that:

(a) another plan exists;

(b) a person is or could have been covered under another plan;

(c) a person has elected an option under another plan providing a lower level of benefits than another option which could have been elected; or

(d) a person did not follow a provision found in a primary plan.

(2) No contract may contain a provision that its benefits are "excess" or "always secondary" to any plan as defined in 211 CMR 38.00, except in accord with the rules permitted by 211 CMR 38.00.

38.07: Procedure to be Followed by Secondary Plan

(1) A secondary plan may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than total allowable expenses. The amount by which the secondary plan's benefits have been reduced shall be used by the secondary plan to pay allowable expenses, not otherwise paid, which were incurred during the claim determination period by the person for whom the claims are made. As each claim is submitted, the secondary plan determines its obligation to pay for allowable expenses based on all claims which were submitted up to that point in time during the claim determination period.

(2) The benefits of the secondary plan will be reduced when the sum of the benefits that would be payable for the allowable expenses under the secondary plan in the absence of 211 CMR 38.07 and the benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of 211 CMR 38.07, whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of the secondary plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

38.07: continued

(a) When the benefits of the secondary plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the plan.
(b) 211 CMR 38.07(2)(a) may be omitted if the plan provides only one benefit or benefits in the form of services.

38.08: Miscellaneous Provisions

(1) A secondary plan which provides benefits in the form of services may recover the reasonable value of the services from the primary plan, subject to the provisions governing allowable expense and claim determination period. Nothing in this provision shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan which provides benefits in the form of services.

(2) A plan which pays for or provides more benefits than it should have under 211 CMR 38.00 may recover the excess from one or more of:
(a) the person it has paid;
(b) insurance companies; or
(c) other organizations.

(3) A plan with order of benefit determination rules which comply with 211 CMR 38.00 ("complying plan") may coordinate its benefits with a plan which is "excess" or "always secondary" or which uses order of benefit determination rules which are inconsistent with those contained in 211 CMR 38.00 ("noncomplying plan") on the following basis:
(a) if the complying plan is the primary plan, it shall pay or provide its benefits on a primary basis;
(b) if the complying plan is the secondary plan, it shall, nevertheless, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In such a situation, such payment shall be the limit of the complying plan's liability; and
(c) if the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the noncomplying plan are identical to its own, and shall pay its benefits accordingly. However, the complying plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the noncomplying plan.

38.09: Effective Date

211 CMR 38.00 is applicable to any plan contract covering residents of the Commonwealth which is issued or renewed within or without the Commonwealth on or after the effective date of 211 CMR 38.00.

A plan contract which was issued before the effective date of 211 CMR 38.00 shall be brought into compliance with 211 CMR 38.00 by the later of:

(1) the next anniversary date or renewal date of the group contract; or

(2) the expiration of any applicable collectively bargained contract pursuant to which it was written.

38.10: Severability

If any provision of 211 CMR 38.00 or the applicability thereof to any person, entity or circumstance is held invalid by a court, the remainder of 211 CMR 38.00 or the applicability of such provision to other persons, entities or circumstances shall not be affected thereby.

REGULATORY AUTHORITY

211 CMR 38.00: M.G.L. chs. 175, 176A, 176B, 176C, 176D, 176E, 176F, 176G and 176I.

NON-TEXT PAGE